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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04077

4101

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN RURAL - Bel Air</u>		LENGTH OF STAY (in this place) <u>9 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL - Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>near Hickory</u>			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
		<u>JOHN</u>		<u>HENRY</u>		<u>ANDERSON</u>	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
		<u>April</u>		<u>18</u>		<u>19 56</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>September 25, 1887</u>		<u>68</u> yrs.	Months	Days
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			12. KIND OF BUSINESS OR INDUSTRY			13. BIRTHPLACE (State or foreign country)	
<u>Farmer</u>						<u>North Carolina</u>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. CITIZEN OF WHAT COUNTRY?	
<u>Riley Anderson</u>			<u>Matilda Landis</u>			<u>U. S. A.</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			18. SOCIAL SECURITY NO.			19. INFORMANT & ADDRESS	
<u>no</u>						<u>Elmer R. Anderson (son), Aberdeen, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
1. IMMEDIATE CAUSE (A)							<u>4 weeks</u>
<u>Cerebro-vascular accident</u>							
2. ANTECEDENT CAUSE(S) DUE TO							<u>indefinite</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
3. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							<u>5 weeks</u>
<u>Recent prostatectomy for benign hypertrophy</u>							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	
						(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					
22. I hereby certify that I attended the deceased from <u>April 12, 1956</u>, to <u>April 18, 1956</u>, that I last saw the deceased alive on <u>April 18, 1956</u>, and that death occurred at <u>11:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Paul S. Stomawife Jr.</u>				<u>Apr. 19, 1956</u>			
ADDRESS (Street, city, town, state)				DATE SIGNED			
<u>M.D. 115 Fulford Ave., Bel Air, Md.</u>				<u>Apr. 19, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>April 21/56</u>		<u>Rock Spring Baptist</u>		<u>LANCASTER CO PENN.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>4-20-56</u>		<u>Priscilla Lowwood</u>		<u>Joseph T. Foster</u>		<u>Bel Air Md</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE	
At Home		Male		45	
4. OCCUPATION		5. MARITAL STATUS		6. CAUSE OF DEATH	
None		Married		Heart Disease	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF BURIAL	
April 1, 1956		10:00 AM		Catholic Cemetery	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
[Signature]		[Signature]		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JUDGE	
[Signature]		[Signature]		[Signature]	

RECEIVED
APR 23 1956
BUREAU V. S.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford 182</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hess, Monkton</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hess, — Monkton, RD</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>			d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carrie Wilson Ansell</u>			4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1869</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Louise Ketten</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Mrs Bernard McKennie, Monkton</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Lerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/1/56</u>	
EXAMINER'S NAME (Type) <u>Gerzild C. Palmer</u>		DISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 4/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Rural</u>	22d. LOCATION (City, town, or county) <u>Chester</u>	(State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Hutz</u>		ADDRESS <u>Janettsville Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/3/56</u>	24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, date of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

APR 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04079

Item 7, Film G197 5-14-56 et

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>RD</u>	
3. NAME OF DECEASED (Type or print) <u>Paul Spencer Bishop</u>		4. DATE OF DEATH <u>April 20 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUSSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Jerome Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Sara A. Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-36-7835</u>	
17. INFORMANT <u>OSCAR J. Bishop</u>		Address <u>HAYRE DE GRACE P.D. NO.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound, comminuted</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c) <u>—</u> DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound Fracture femur + tibia</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>April 20 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD Hart-de-grace</u>		20f. City or town <u>Hartford</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>APR 23 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gravel Hill</u>		22d. LOCATION (City, town, or county) <u>Hartford</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u>		ADDRESS <u>Hartford</u>	
24a. REC'D BY REGISTRAR <u>APR 23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Willie H. Perry</u>	



APR 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4104

CERTIFICATE OF DEATH

04080

Reg. Dist. No. 181

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural. 2</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Level Area.</u>		d. STREET ADDRESS <u>Level Area.</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Webster Bowman.</u>		4. DATE OF DEATH Month Day Year <u>April 23rd 1956</u>	
5. SEX <u>Male.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14 - 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James S. Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Gorrell.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Wm. Minna J. Taylor Aberdeen 2. Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>✓</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/22</u> , 19 <u>56</u> , to <u>4/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>56</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.P. Smogor</u>		ADDRESS (Street, city or town, state) <u>Darlington Md.</u>	
PHYSICIAN'S NAME (Type) <u>E.P. Smogor</u>		DATE SIGNED <u>4/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Haver de Grace R. 7 Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarving</u>		ADDRESS <u>Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR <u>Apr. 26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Willie G. Perry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1109

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. S.

APR 27 1956

RECEIVED

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. THE ORIGINAL COPY OF THIS CERTIFICATE IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. THE COPY OF THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4105

CERTIFICATE OF DEATH

04081

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Hartford</u>	STATE <u>Md</u>	COUNTY <u>Hartford</u>	STATE <u>Md</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
(First) <u>Charles</u> (Middle) <u>Hilditch</u> (Last) <u>Burkins</u>		<u>April</u> <u>30</u> 19 <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 13 1898</u>
9. AGE last birthday <u>57</u> yrs.		10. F UNDER 1 YEAR <u> </u> Months <u> </u> Days <u> </u> Hours <u> </u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Hartford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Burkins</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hilditch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-24-1456</u>	
17. INFORMANT & ADDRESS <u>Sarah Knopp Burkins Forest Hill Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <u>Carcinoma rectum with wide</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>Feb 15 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma +osis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>56</u> , to <u>4/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>56</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Lorald e Palmer</u>		DATE SIGNED <u>4/30/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
24. REC'D BY REGISTRAR <u>Shwella Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lister</u>	
DATE <u>4-30-56</u>		ADDRESS <u>Bel Air Md</u>	

CERTIFICATE OF DEATH

brother
11, 4 1956

brother
11, 4 1956

April 30 1956

Charles H. B. B. B. B.

W W W

24

brother

metastatic carcinoma of the rectum with sigmoid

brother

BUREAU V. 3

1956

RECEIVED

April 30, 1956

brother

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4087

CERTIFICATE OF DEATH

Reg. Dist. No.

04083

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Part Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Woodlawn Trailer Park</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Campbell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 13, 1956</u>	9. AGE (In years last birthday) yrs. <u>9</u> Min. <u>11</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Franklin Eugene Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Harb. Records Havre de Grace Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYALINE MEMBRANE DISEASE</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY. (Wt 4 LBS 15 oz)</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:45</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.B. Norment M.D.</u>				ADDRESS (Street, city or town, state) <u>Havre de Grace</u> DATE SIGNED <u>4-4-56</u>			
PHYSICIAN'S NAME (Type) <u>R.B. NORMENT</u>				LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Eun</u>		22d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Prangton Rm. Havre de Grace, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 4-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>A.L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10037

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other reliable source. (Signature) _____ (Title) _____		I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other reliable source. (Signature) _____ (Title) _____	
Name of Deceased _____ Sex _____ Age _____ Date of Birth _____ Place of Birth _____ Usual Residence _____ Date of Death _____ Time of Death _____ Cause of Death _____ Manner of Death _____ Place of Death _____ Name of Physician _____ Name of Hospital _____ Name of Coroner _____ Name of Registrar _____ Name of Burial Place _____ Name of Undertaker _____ Name of Funeral Home _____ Name of Cemetery _____ Name of Interment _____ Name of Burial Place _____ Name of Undertaker _____ Name of Funeral Home _____ Name of Cemetery _____ Name of Interment _____		Name of Deceased _____ Sex _____ Age _____ Date of Birth _____ Place of Birth _____ Usual Residence _____ Date of Death _____ Time of Death _____ Cause of Death _____ Manner of Death _____ Place of Death _____ Name of Physician _____ Name of Hospital _____ Name of Coroner _____ Name of Registrar _____ Name of Burial Place _____ Name of Undertaker _____ Name of Funeral Home _____ Name of Cemetery _____ Name of Interment _____ Name of Burial Place _____ Name of Undertaker _____ Name of Funeral Home _____ Name of Cemetery _____ Name of Interment _____	

BUREAU V. S.

APR 6 1956

RECEIVED

4088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>151 W. Deen Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert A. Carlton</u>		4. DATE OF DEATH <u>April 25 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Oct. 1914</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Carlton</u>		14. MOTHER'S MAIDEN NAME <u>Marita Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Current</u>		16. SOCIAL SECURITY NO. <u>521-18-8572</u>	
17. INFORMANT <u>Renée Carlton</u>		Address <u>151 W. Deen ave. Aber.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>802x</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by Train</u>	
20c. TIME OF INJURY Month, Day, Year <u>Apr. 25 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pennington Rd.</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>Hartford</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		DATE SIGNED <u>4/26/56</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>30 Apr. 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Va.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarrington</u>		24a. REC'D BY REGISTRAR <u>Apr 30 56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Nellie G. Perry</u>	

MEDICAL CERTIFICATION

31

50

1

2

12

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate noting the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4789

CERTIFICATE OF DEATH

04084

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air			
c. LENGTH OF STAY IN 1b 1 year				d. STREET ADDRESS Webster Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIA Middle MONNETT Last CASS				4. DATE OF DEATH Month April Day 20 Year 19 56			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1874		9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Abram Monnett				14. MOTHER'S MAIDEN NAME Jane Walwork			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth Wills (daughter), Bel Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, terminal 154x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Carcinomatosis, general DUE TO (c) Adenocarcinoma of rectum, grade I							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 month 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 2 , 19 56 , to April 20 , 19 56 , that I last saw the deceased alive on April 19 , 19 56 , and that death occurred at 3:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 Fulford Ave., Bel Air, Md. DATE SIGNED 4/20/56							
ACTUAL SIGNATURE Paul S. Stonesifer Jr. M.D.				PHYSICIAN'S NAME (Type) Paul S. Stonesifer, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Bucyrus Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Archer				ADDRESS Benson - Md		24a. REC'D BY REGISTRAR DATE 4-28-56	
				24b. REGISTRAR'S SIGNATURE Russella Lowmnd			

CERTIFICATE OF DEATH

4-1956

DEPARTMENT OF HEALTH BALTIMORE		COUNTY OF BALTIMORE CITY OF BALTIMORE	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]	
RELIGION [Illegible]		MARITAL STATUS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	

BUREAU V. S.

MAY 1 1956

RECEIVED

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

1 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04085

4106 **CERTIFICATE OF DEATH**Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY <u>Barlingtton</u> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY <u>Life</u> (in this place)	CITY <u>Barlingtton</u> (If outside corporate limits, write RURAL and give nearest town)	TOWN <u>Barlingtton</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Emma</u> (Middle) <u>May</u> (Last) <u>Chandler</u>		(Month) <u>April</u> (Day) <u>30</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 31, 1882</u>
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Geo. Henry White</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah E. Gates</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, pay or unk.) <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mr. Harner, White</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
19a. DATE OF OPERATION <u>450.0</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ante Heart failure</u>	
IMMEDIATE CAUSE (A) <u>Ante Heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>		<u>4 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u>, 19<u>50</u>, to <u>May 30</u>, 19<u>56</u>, that I last saw the deceased alive on <u>May 30</u>, 19<u>56</u>, and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Dudley Phillips, M.D.</u>		DATE SIGNED <u>5/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR	
DATE THEREOF <u>May 3, 1956</u>		REGISTRAR'S SIGNATURE <u>C. H. Kirk</u>	
NAME OF CEMETERY OR CREMATORY <u>Barlingtton - Cem.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Eds Bailey</u>	
LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>		ADDRESS <u>Barlingtton, Md.</u>	

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. PLACE OF DEATH: _____

9. TIME OF DEATH: _____

10. SIGNATURE OF PHYSICIAN: _____

11. SIGNATURE OF OTHER PERSON: _____

12. SIGNATURE OF WITNESS: _____

13. SIGNATURE OF DECEASED: _____

14. SIGNATURE OF PHYSICIAN: _____

15. SIGNATURE OF OTHER PERSON: _____

16. SIGNATURE OF WITNESS: _____

17. SIGNATURE OF DECEASED: _____

18. SIGNATURE OF PHYSICIAN: _____

19. SIGNATURE OF OTHER PERSON: _____

20. SIGNATURE OF WITNESS: _____

21. SIGNATURE OF DECEASED: _____

22. SIGNATURE OF PHYSICIAN: _____

23. SIGNATURE OF OTHER PERSON: _____

24. SIGNATURE OF WITNESS: _____

25. SIGNATURE OF DECEASED: _____

26. SIGNATURE OF PHYSICIAN: _____

27. SIGNATURE OF OTHER PERSON: _____

28. SIGNATURE OF WITNESS: _____

29. SIGNATURE OF DECEASED: _____

30. SIGNATURE OF PHYSICIAN: _____

31. SIGNATURE OF OTHER PERSON: _____

32. SIGNATURE OF WITNESS: _____

33. SIGNATURE OF DECEASED: _____

BUREAU V. 5

MAY 7 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate pending the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05171	
Item 21: film G198 6-5-56L										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital DOA					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Penna b. COUNTY Lancaster c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster d. STREET ADDRESS 1103 New Holland av. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First PAUL Middle EUGENE Last CHECKLEY					4. DATE OF DEATH Month April Day 26, Year 1956						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1914		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner and Manager				10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME HARRY CHECKLEY					14. MOTHER'S MAIDEN NAME HELEN KLOSE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 196 10 9887			17. INFORMANT Mrs. Paul Checkley Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Gerald C. Palmer M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 4/26/56			
EXAMINER'S NAME (Type) GERALD C. PALMER					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Home, Lancaster Pa.					24a. REC'D BY REGISTRAR DATE 6/8/56		24b. REGISTRAR'S SIGNATURE a. H. Hedrick				

BUREAU V. S.

JUN 8 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04086

4108

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EMMERTON</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EMMERTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FANNIE</u> (Middle) <u>COCHRAN</u> (Last) <u>X</u>				(Month) <u>April</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct 27 - 1920</u>	9. AGE last birthday <u>35</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>W M Cole</u>				14. MOTHER'S MAIDEN NAME <u>SORRY Christian</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Clinton Cochran Bel Air Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <u>Carcinoma Cervix Uteri</u>						8 mo.	
ANTECEDENT CAUSE(S) DUE TO <u>with wide metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6/1/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma cervix</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/15</u> , 19 <u>55</u> , to <u>4/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>56</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Lerald C Palmer</u> M.D.				ADDRESS (Street, city, town, state) <u>Bel Air Md.</u>		DATE SIGNED <u>4/7/56</u>	
23. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		DATE THEREOF <u>April 12/56</u>		NAME OF CEMETERY OR CREMATOR <u>Wilmington Baptist</u>		LOCATION (City, town, or county) (State) <u>Hickory, Hartford Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4-12-56</u>		REGISTRAR'S SIGNATURE <u>Prueella Lowood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster Bel Air, Md.</u>			

INSTRUCTIONS:

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF CORONER

26. SIGNATURE OF JURY

27. SIGNATURE OF JUDGE

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF CORONER

30. SIGNATURE OF JURY

31. SIGNATURE OF JUDGE

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF CORONER

34. SIGNATURE OF JURY

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

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38. SIGNATURE OF JURY

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49. SIGNATURE OF CORONER

50. SIGNATURE OF JURY

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70. SIGNATURE OF JURY

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73. SIGNATURE OF CORONER

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78. SIGNATURE OF JURY

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81. SIGNATURE OF CORONER

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101. SIGNATURE OF CORONER

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103. SIGNATURE OF JUDGE

104. SIGNATURE OF SHERIFF

105. SIGNATURE OF CORONER

106. SIGNATURE OF JURY

107. SIGNATURE OF JUDGE

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110. SIGNATURE OF JURY

111. SIGNATURE OF JUDGE

112. SIGNATURE OF SHERIFF

113. SIGNATURE OF CORONER

114. SIGNATURE OF JURY

115. SIGNATURE OF JUDGE

116. SIGNATURE OF SHERIFF

117. SIGNATURE OF CORONER

118. SIGNATURE OF JURY

119. SIGNATURE OF JUDGE

120. SIGNATURE OF SHERIFF

121. SIGNATURE OF CORONER

122. SIGNATURE OF JURY

BUREAU V. S.

APR 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4109 CERTIFICATE OF DEATH

04087

Reg. Dist. No. 186

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen RURAL X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 US Army Hospital Aberdeen Proving Ground, Md				d. STREET ADDRESS RED #2 Poplar Hill			
3. NAME OF DECEASED (Type or print) First James Middle Thomas Last Connelly				4. DATE OF DEATH Month April Day 14 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14 1956		9. AGE (In years last birthday) — yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Joseph Connelly Jr				14. MOTHER'S MAIDEN NAME Gertrude Mary Burgess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father (as in 2) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Maternal congenital anomalies of uterus DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 7 hr 48 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Apr , 19 56 , to 14 Apr , 19 56 , that I last saw the deceased alive on 14 Apr , 19 56 , and that death occurred at 1030 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital Aberdeen PG Md DATE SIGNED 14 Apr 56							
ACTUAL SIGNATURE V. G. Coseriu Capt MC		PHYSICIAN'S NAME (Type) V. G. COSERIU Capt MC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/56		22c. NAME OF CEMETERY OR CREMATORY Fort Detmer		22d. LOCATION (City, town, or county) (State) Aberdeen Harford Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarning Aberdeen, Md.				24a. REC'D BY REGISTRAR DATE Apr 17 56		24b. REGISTRAR'S SIGNATURE Nellie G. Perry	

2050212XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1999

RECEIVED
APR 19 1956

4110

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY <u>Harford.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Creswell Road.</u>		d. STREET ADDRESS <u>Creswell Road.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Charles Eisner</u>		4. DATE OF DEATH <u>April 7th 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Eisner</u>		14. MOTHER'S MAIDEN NAME <u>Christine Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert H. Eisner - 215 Park St. Aberdeen Md.</u>		Address <u>215 Park St. Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V. Disease</u> DUE TO (c) <u>10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>70</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph Horky</u> M.D.		ADDRESS (Street, city or town, state) <u>Churchville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Ralph Horky MD</u>		DATE SIGNED <u>April 7</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Babers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrung</u>		ADDRESS <u>Aberdeen Md.</u>	
24a. REC'D BY REGISTRAR <u>April 9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie G. Perry</u>	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4110

BUREAU V. 3

APR 10 1956

RECEIVED

4111

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BELAIR				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle ENFIELD Last ENFIELD				4. DATE OF DEATH Month APR. Day 11 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN 28, 1873		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - RETIRED				10b. KIND OF BUSINESS OR INDUSTRY AGRI.		11. BIRTHPLACE (State or foreign country) HARFORD CO., MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WM. ENFIELD			
14. MOTHER'S MAIDEN NAME TACY WEEKS				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. —				17. INFORMANT MRS. BESSIE S. ENFIELD, FOREST HILL, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO (c) Chr. cardio-vascular disease						INTERVAL BETWEEN ONSET AND DEATH 48 hrs 8-10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic hypertrophy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 1946 to April 11, 1956 , that I last saw the deceased alive on April 11, 1956 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Hudson				ADDRESS (Street, city or town, state) Forest Hill, Md.			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				DATE SIGNED 4-11-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-14-56		22c. NAME OF CEMETERY OR CREMATORY SLATEVILLE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins				ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR 4-13-56	
						24b. REGISTRAR'S SIGNATURE Priscilla Toward	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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Mrs.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4112 CERTIFICATE OF DEATH

04090

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford Co.</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Forest Hill</u>	<u>Entire life</u> <u>479+5</u>	TOWN <u>Forest Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>ARIEL STANDIFORD</u>		<u>April 11 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Apr. 1st 1984</u>
9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>72</u> yrs.	Months Days		Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Housewife</u>			<u>Ind.</u>
12. CITIZEN OF WHAT COUNTRY?			
<u>U.S.A.</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Charles R. Standiford</u>		<u>Cassandra Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>Frank O Foard</u>	
17. INFORMANT & ADDRESS			
<u>Forest Hill</u>		<u>Ind</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>153X</u> IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>			<u>48 hours.</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
<u>260X</u> (C) <u>Adeno-carcinoma of large intestines with generalized metastases.</u>			<u>1</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Diabetes Mellitus; Arthritis</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>March 14, 1956</u>	<u>Carcinoma of transverse colon; Generalized metastases.</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 52</u> , to <u>April 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Willard P. Hudson</u> M.D.		<u>April 12, 1956</u>	
ADDRESS (Street, city, town, state)			
<u>Forest Hill</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Apr 13-56</u>	<u>Centre</u>	<u>Forest Hill Maryland</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE <u>4-16-56</u>	<u>P. Wallace Howard</u>	<u>Martha Knight</u>	<u>Janet Wallace Ind</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF ASSISTANT

18. SIGNATURE OF CLERK

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4113

CERTIFICATE OF DEATH

Reg. Dist.

140981

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>338 Parke Street.</u>				d. STREET ADDRESS <u># 338 A. Parke Street.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>O.</u> Last <u>Gallione</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1956.</u>					
5. SEX <u>Female.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8th 1873</u>	9. AGE (In years last birthday) <u>83.</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Greenland.</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Pullum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None.</u>		17. INFORMANT Address <u>Lester G. Gallione Aberdeen Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Anemia</u> (c) <u>Heart Block</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Term. ind</u> <u>2 wk</u> <u>2 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-22-</u> , 19 <u>55</u> to <u>4-13-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-12-56</u> , 19 <u>56</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D. <u>Peter P. Rodman, M.D.</u> PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Farring</u> ADDRESS <u>Aberdeen Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>Apr. 15-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie E. Perry</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1113

NAME OF DECEASED <i>JOHN J. JACKSON</i>		AGE <i>75</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1881</i>		PLACE OF BIRTH <i>MD</i>	
MANNER OF DEATH <i>NATURAL</i>		CAUSE OF DEATH <i>HEART DISEASE</i>		IMMEDIATE CAUSE <i>MYOCARDIAL INFARCTION</i>		DISEASE OR INJURY <i>ARTERIOSCLEROSIS</i>		DURATION OF ILLNESS <i>2 WEEKS</i>		PLACE OF DEATH <i>HOME</i>	
DATE OF DEATH <i>APR 17 1956</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>HOME</i>		NAME OF PHYSICIAN <i>DR. J. H. SMITH</i>		NAME OF NURSE <i>MRS. J. H. SMITH</i>		NAME OF ATTENDING CLERGYMAN <i>REVEREND J. H. SMITH</i>	
SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF NURSE <i>[Signature]</i>		SIGNATURE OF ATTENDING CLERGYMAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
NAME OF NEXT OF KIN <i>MRS. J. H. JACKSON</i>		ADDRESS OF NEXT OF KIN <i>1234 E. BALTIMORE ST.</i>		CITY <i>BALTIMORE</i>		STATE <i>MD</i>		ZIP CODE <i>21201</i>		TELEPHONE <i>555-1234</i>	
NAME OF PHYSICIAN <i>DR. J. H. SMITH</i>		ADDRESS OF PHYSICIAN <i>5678 N. BALTIMORE ST.</i>		CITY <i>BALTIMORE</i>		STATE <i>MD</i>		ZIP CODE <i>21201</i>		TELEPHONE <i>555-5678</i>	
NAME OF NURSE <i>MRS. J. H. SMITH</i>		ADDRESS OF NURSE <i>9010 W. BALTIMORE ST.</i>		CITY <i>BALTIMORE</i>		STATE <i>MD</i>		ZIP CODE <i>21201</i>		TELEPHONE <i>555-9010</i>	
NAME OF ATTENDING CLERGYMAN <i>REVEREND J. H. SMITH</i>		ADDRESS OF ATTENDING CLERGYMAN <i>1111 S. BALTIMORE ST.</i>		CITY <i>BALTIMORE</i>		STATE <i>MD</i>		ZIP CODE <i>21201</i>		TELEPHONE <i>555-1111</i>	
NAME OF REGISTRAR <i>[Signature]</i>		ADDRESS OF REGISTRAR <i>1212 E. BALTIMORE ST.</i>		CITY <i>BALTIMORE</i>		STATE <i>MD</i>		ZIP CODE <i>21201</i>		TELEPHONE <i>555-1212</i>	

BUREAU V. S.

APR 17 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04092

4107

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill</u>		LENGTH OF STAY (In this place) <u>1 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (First) (Middle) (Last) <u>Dora Phipps Goss</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 13 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 6-1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fox, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Floyd Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide Standiford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Floyd Goss Forest Hill Md RD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema.</u>						<u>48 hours.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic hypertensive cardio-vascular disease.</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis.</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19</u> , 19 <u>56</u> , to <u>April 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>56</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above. SIGNATURE <u>William A. Hedrick</u> ADDRESS (Street, city, town, state) <u>Forest Hill</u> DATE SIGNED <u>April 13, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>April 16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Grove Baptist</u>		LOCATION (City, town, or county) (State) <u>Schuicks Corner Harford Md</u>	
24. REC'D BY REGISTRAR <u>Purcella Townsend</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. [unclear] Belton</u>			
DATE <u>4-14-56</u>							

4091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b one day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air,	
f. STREET ADDRESS 129 Thomas Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Corene Middle Haughay Last Haughay		4. DATE OF DEATH Month April Day 10 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1870
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Haughay		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. Paul Haughay		Address Wilmington Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture R. femur 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <input type="checkbox"/> (c), stating the underlying cause lost. DUE TO (c) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH one day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor of her room	
20c. TIME OF INJURY Month, Day, Year April 9, 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Bel Air Harford Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gerald C. Palmer		DATE SIGNED April 10, 1956	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried April 13, 1956	22b. DATE THEREOF April 13, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Ignace Cn	22d. LOCATION (City, town, or county) (State) Harford Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Bailey		24a. REC'D BY REGISTRAR April 17, 1956	
ADDRESS Wilmington, Md.		24b. REGISTRAR'S SIGNATURE G. L. Lewis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be signed by the medical examiner and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Civil Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 13 1956

RECEIVED

4114

CERTIFICATE OF DEATH

Reg. Dist. No. 1803

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor - Monkton R.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Monkton R.D.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Montgomery</u> Middle <u>Hill</u> Last		4. DATE OF DEATH <u>Apr.</u> Month <u>20</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14 1863</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Burwin Wis.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carlton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Edward J. Mc Dermott</u>		Address <u>Monkton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia,</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Congestive Heart Failure</u> DUE TO <u>Hypertensive arteriosclerosis Ht. Dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4/12 - 4/18/56</u> <u>4/6 - 4 - 29/56</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>56</u> , to <u>April 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>56</u> , and that death occurred at <u>8:20</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Janettsville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>S. James Thomison, Jr.</u> M.D.		DATE SIGNED <u>4/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 23-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Krutz</u>		24a. REC'D BY REGISTRAR DATE <u>4-24-56</u>	
ADDRESS <u>Janettsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Foxworth</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 26 1956

RECEIVED

4115 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FAWN GROVE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FAWN GROVE, PA.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First N. Middle OSCAR Last HUNSBERGER				4. DATE OF DEATH Month 4 Day 8 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-1871	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HUNSBERGER				14. MOTHER'S MAIDEN NAME SUSAN ROATS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Thos Walter Swift Fawn Grove Pa Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure due to chronic 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) myocarditis, broncho-pneumonia & DUE TO (c) general infirmities of old age.						INTERVAL BETWEEN ONSET AND DEATH 10 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Stewartstown Pa				20g. (County) PA.		20h. (State) PA.	
21. I certify that I attended the deceased from Mar. 27, 1956 , to Apr. 8, 1956 , that I last saw the deceased alive on Apr. 8, 1956 , and that death occurred at 4:30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman H. Gemmill				ADDRESS (Street, city or town, state) Stewartstown Pa			
DATE SIGNED 4/9/56							
PHYSICIAN'S NAME (Type) Norman H. Gemmill							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-11-56		22c. NAME OF CEMETERY OR CREMATORY FAWN GROVE		22d. LOCATION (City, town, or county) (State) FAWN GROVE, YORK CO., PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Graham				ADDRESS Stewartstown Pa.		24a. REC'D BY REGISTRAR DATE 4-10-56	
				24b. REGISTRAR'S SIGNATURE Bucilla Lowwood			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04096

Reg. Dist. No. 185-

4092

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>P.O. Box 78</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1956</u>		9. AGE (In years last birthday) yrs. <u>23</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>23</u> Days <u>30</u> Hours <u>30</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Calvin Clay Jones</u>				14. MOTHER'S MAIDEN NAME <u>Lulah Lee Gambill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pre-Viable Baby</u> <u>762.5</u> DUE TO <u>Premature Abortion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abortion</u> DUE TO (c) <u>Abortion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>23 1/2 hrs</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4-20</u> , 19 <u>56</u> , to <u>4-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>56</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4-21-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Dally</u> Administrator				24a. REC'D BY REGISTRAR DATE <u>Apr. 24</u> 19 <u>56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis MD</u>	

2071272220

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]		9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]		13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF WITNESS [Faint text]		15. SIGNATURE OF PHYSICIAN [Faint text]		16. SIGNATURE OF MORTUARY [Faint text]		17. SIGNATURE OF FUNERAL HOME [Faint text]		18. SIGNATURE OF BURIAL SOCIETY [Faint text]		19. SIGNATURE OF CEMETERY [Faint text]		20. SIGNATURE OF OTHER [Faint text]			
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	

BUREAU V. S.

APR 25 1956

RECEIVED

FOR FILING IN THE OFFICE OF THE REGISTRAR OF DEATHS
BALTIMORE, MD.
[Faint text]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04097

4116 **CERTIFICATE OF DEATH**

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> OR TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> OR TOWN <u>Harford</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>L Maxwell Knight</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 27 1907</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Overseer Browning Ground</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>R Bernard Knight</u>				14. MOTHER'S MAIDEN NAME <u>Clara S. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>164-10-6413</u>		17. INFORMANT & ADDRESS <u>Mrs. Grace Knight</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Cerebral Artery Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION <u>Harford, Md.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1947</u> , to <u>April 9 1956</u> , that I last saw the deceased alive on <u>April 7 1956</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Malcolm Dudley Phillips</u> M.D.				ADDRESS (Street, city, town, state) <u>Harford, Md</u>			
DATE SIGNED <u>4/12/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 13 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Harford Co. Md</u>		LOCATION (City, town, or county) (State) <u>Harford Co. Md</u>	
24. REC'D BY REGISTRAR <u>April 9 1956</u>		REGISTRAR'S SIGNATURE <u>C. D. Kirk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Harford, Md</u>	

CERTIFICATE OF DEATH

State, Dist. No.

AT ABOUT 11:00 AM ON APRIL 30, 1956

17-78

MARYLAND

WICOMICO COUNTY

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IN MEDICAL CERTIFICATION

AT WICOMICO, WICOMICO COUNTY, MARYLAND

DATE OF DEATH

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BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04098

4093

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 Wt Royal Ave.</u>				d. STREET ADDRESS <u>65 Wt Royal Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Paul Conrad Krouse</u>				4. DATE OF DEATH <u>April 27 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21-1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Steam Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Conrad Krouse</u>				14. MOTHER'S MAIDEN NAME <u>Annice Trexler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-0127</u>		17. INFORMANT <u>Mrs Paul C. Krouse Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>5 yr.</u> <u>5 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1951</u> , to <u>April 27 1956</u> , that I last saw the deceased alive on <u>April 27 1956</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Val P. Krouse M.D.</u>				DATE SIGNED <u>4-30-56</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Karmay</u>				ADDRESS <u>Aberdeen Md.</u>		24. REC'D BY REGISTRAR <u>April 30-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thelma K. Perry</u>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of zoologist		38. Signature of botanist		39. Signature of geologist	
40. Signature of meteorologist		41. Signature of climatologist		42. Signature of oceanographer	
43. Signature of astronomer		44. Signature of physicist		45. Signature of chemist	
46. Signature of biologist		47. Signature of geophysicist		48. Signature of environmental scientist	
49. Signature of earth scientist		50. Signature of space scientist		51. Signature of planetary scientist	
52. Signature of solar scientist		53. Signature of stellar scientist		54. Signature of galactic scientist	
55. Signature of cosmic scientist		56. Signature of intergalactic scientist		57. Signature of extragalactic scientist	
58. Signature of supergalactic scientist		59. Signature of megagalactic scientist		60. Signature of gigagalactic scientist	
61. Signature of petagalactic scientist		62. Signature of topogalactic scientist		63. Signature of megagalactic scientist	
64. Signature of gigagalactic scientist		65. Signature of petagalactic scientist		66. Signature of topogalactic scientist	
67. Signature of megagalactic scientist		68. Signature of gigagalactic scientist		69. Signature of petagalactic scientist	
70. Signature of topogalactic scientist		71. Signature of megagalactic scientist		72. Signature of gigagalactic scientist	
73. Signature of petagalactic scientist		74. Signature of topogalactic scientist		75. Signature of megagalactic scientist	
76. Signature of gigagalactic scientist		77. Signature of petagalactic scientist		78. Signature of topogalactic scientist	
79. Signature of megagalactic scientist		80. Signature of gigagalactic scientist		81. Signature of petagalactic scientist	
82. Signature of topogalactic scientist		83. Signature of megagalactic scientist		84. Signature of gigagalactic scientist	
85. Signature of petagalactic scientist		86. Signature of topogalactic scientist		87. Signature of megagalactic scientist	
88. Signature of gigagalactic scientist		89. Signature of petagalactic scientist		90. Signature of topogalactic scientist	
91. Signature of megagalactic scientist		92. Signature of gigagalactic scientist		93. Signature of petagalactic scientist	
94. Signature of topogalactic scientist		95. Signature of megagalactic scientist		96. Signature of gigagalactic scientist	
97. Signature of petagalactic scientist		98. Signature of topogalactic scientist		99. Signature of megagalactic scientist	
100. Signature of gigagalactic scientist		101. Signature of petagalactic scientist		102. Signature of topogalactic scientist	

RECEIVED
MAY 2 1956
BUREAU V. 8

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04099

4094 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Bel Air,</u>		LENGTH OF STAY (In this place) <u>5 Mo.</u>		TOWN <u>Forest Hill</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Convalescent Home</u>				ADDRESS <u>Forest Hill</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Ernest Lackey</u>				<u>April 30 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>February 2, 1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black Smith</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Lackey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Bunce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis (Acute)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>See above</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Decompensated Cardio- Vascular Disease</u>				<u>141.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arterio-sclerosis</u>				<u>7</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1952</u> , to <u>April 30, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>6:00 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>April 30, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>May 5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Spring Episcopal</u>		LOCATION (City, town, or county) <u>Forest Hill Harford Md</u>	
24. REC'D BY REGISTRAR <u>4-30-56</u>		REGISTRAR'S SIGNATURE <u>Bessie Louwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Bel Air</u>		ADDRESS	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
1956 CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWN CLERK

21. SIGNATURE OF VITAL RECORDS CLERK

22. SIGNATURE OF DECEASED'S NEAREST RELATIVE

23. SIGNATURE OF DECEASED'S NEXT OF KIN

24. SIGNATURE OF DECEASED'S ESTATE

25. SIGNATURE OF DECEASED'S SURVIVORS

26. SIGNATURE OF DECEASED'S ESTATE

27. SIGNATURE OF DECEASED'S SURVIVORS

28. SIGNATURE OF DECEASED'S ESTATE

29. SIGNATURE OF DECEASED'S SURVIVORS

BUREAU V. S.

MAY 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4117

CERTIFICATE OF DEATH

04100

Reg. Dist. No. 18

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 US Army Hospital Aberdeen Proving Ground, Md				d. STREET ADDRESS 301 Market Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Nellie Livingston				4. DATE OF DEATH Month Day Year April 22 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None Home		11. BIRTHPLACE (State or foreign country) Grand Rapids, Michigan	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adrian Baker				14. MOTHER'S MAIDEN NAME Jacoba Klaassen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-22-9573		17. INFORMANT Carl S Livingston	
Address 1411 Hillcrest NW Grand Rapids, Michigan							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Esophageal varices with massive hemorrhage DUE TO (b) Cirrhosis of the liver DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
INTERVAL BETWEEN ONSET AND DEATH 39 hrs 7 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 21 Apr, 1956, to 22 Apr, 1956, that I last saw the deceased alive on 22 Apr, 1956, and that death occurred at 1157P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. S. WHITMAN, Capt MC US Army Hospital Aberdeen PG Md 23 Apr 56							
ACTUAL SIGNATURE R. S. WHITMAN				M.D. US Army Hospital Aberdeen PG Md			
PHYSICIAN'S NAME (Type) R. S. WHITMAN, Capt MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/56		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Fanning				ADDRESS Aberdeen Md.		24a. REC'D BY REGISTRAR DATE 4-25-56	
24b. REGISTRAR'S SIGNATURE Nellie K Perry							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04101

4095 CERTIFICATE OF DEATH

Reg. Dist. No. 186-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Hartford</i>		STATE <i>Maryland</i>		COUNTY <i>Hartford</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harver de Grace</i>		LENGTH OF STAY (in this place) <i>56 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harver de Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hartford Memorial Hospital</i>		STREET ADDRESS (If rural give location) <i>354 W. W. St.</i>					
3. NAME OF DECEASED (Type or Print) <i>John Taylor Maurice</i>				4. DATE OF DEATH (Month) <i>April</i> (Day) <i>9</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>9/17/90</i>	9. AGE last birthday <i>65</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Aberdeen, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frank Maurice</i>				14. MOTHER'S MAIDEN NAME <i>Annie (Thalman)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not.) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT & ADDRESS <i>Emmie S. Maurice, Harver de Grace, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE (A) <i>Pulmonary Edema</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Myocarditis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Cardiac Insufficiency</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-9-56</i> to <i>Apr 9-56</i> , that I last saw the deceased alive on <i>Apr 9-56</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>G. L. Lewis M.D.</i>				ADDRESS (Street, city, town, state) <i>Harver de Grace - Apr. 11-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/12/56</i>		NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		LOCATION (City, town, or county) (State) <i>Harver de Grace, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>James J. ...</i>		ADDRESS <i>Harver de Grace, Md.</i>	
DATE <i>Apr. 11-1956</i>							

RECEIVED
 APR 18 1956
 BUREAU V. S.

James M. ...

James ...

25/7/56

405B CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

1. Name of deceased (Print or type)
 2. Sex
 3. Date of birth (Month, day, year)
 4. Place of birth (City, State, Country)
 5. Race
 6. Marital status (Married, Single, Widowed, Divorced)
 7. Usual residence (Street, City, State, Country)
 8. Date of death (Month, day, year)
 9. Time of death (Hour, minute)
 10. Place of death (City, State, Country)
 11. Cause of death (List all causes, beginning with the immediate cause, and giving the underlying cause)
 12. Signature of attending physician (Print name and type)
 13. Signature of medical examiner (Print name and type)
 14. Signature of coroner (Print name and type)
 15. Signature of registrar (Print name and type)

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04102

4118 CERTIFICATE OF DEATH

Reg. Dist. No. 182.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WHITEFORD RD#1</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL WHITEFORD RD#1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>CHARLOTTE ELIZABETH MERRYMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-18-1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11-18-1877</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>HARFORD Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>AMOS D. HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE CLARK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>H. Clayton Merryman Whiteford RD#1 Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Gangren of left foot</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-vascular-renal disease</u>		<u>4 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral thrombosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
22. I hereby certify that I attended the deceased from <u>April 9, 1956</u> , to <u>April 18, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Edward H. Tyson</u>		ADDRESS (Street, city, town, state) <u>Fawn Grove Pa.</u>	
DATE SIGNED <u>4/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4-21-56</u>	NAME OF CEMETERY OR CREMATORY <u>FAWN GROVE</u>	LOCATION (City, town, or county) (State) <u>FAWN GROVE, YORK Co., Pa.</u>
24. REC'D BY REGISTRAR <u>4-20-56</u>	REGISTRAR'S SIGNATURE <u>Bricella Louwood</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Graham</u>	
DATE		ADDRESS <u>Stewartstown Pa.</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH

04105

BUREAU V. B.

APR 24 1956

RECEIVED

COMMONWEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04103

4119

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH - COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa - Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Old Philadelphia Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Abraham</u> (Middle) <u>Millstein</u> (Last) <u>Millstein</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>60 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothier</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Israel</u>		14. MOTHER'S MAIDEN NAME <u>Kachael</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sarah Millstein - Same</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

5 min +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Atherosclerosis1 yr. +(c) Coronary thrombosis August 1955

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Asthma

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 11, 1955, to Apr. 22, 1956, that I last saw the deceasedalive on Feb. 17, 1956, and that death occurred at 6:35 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

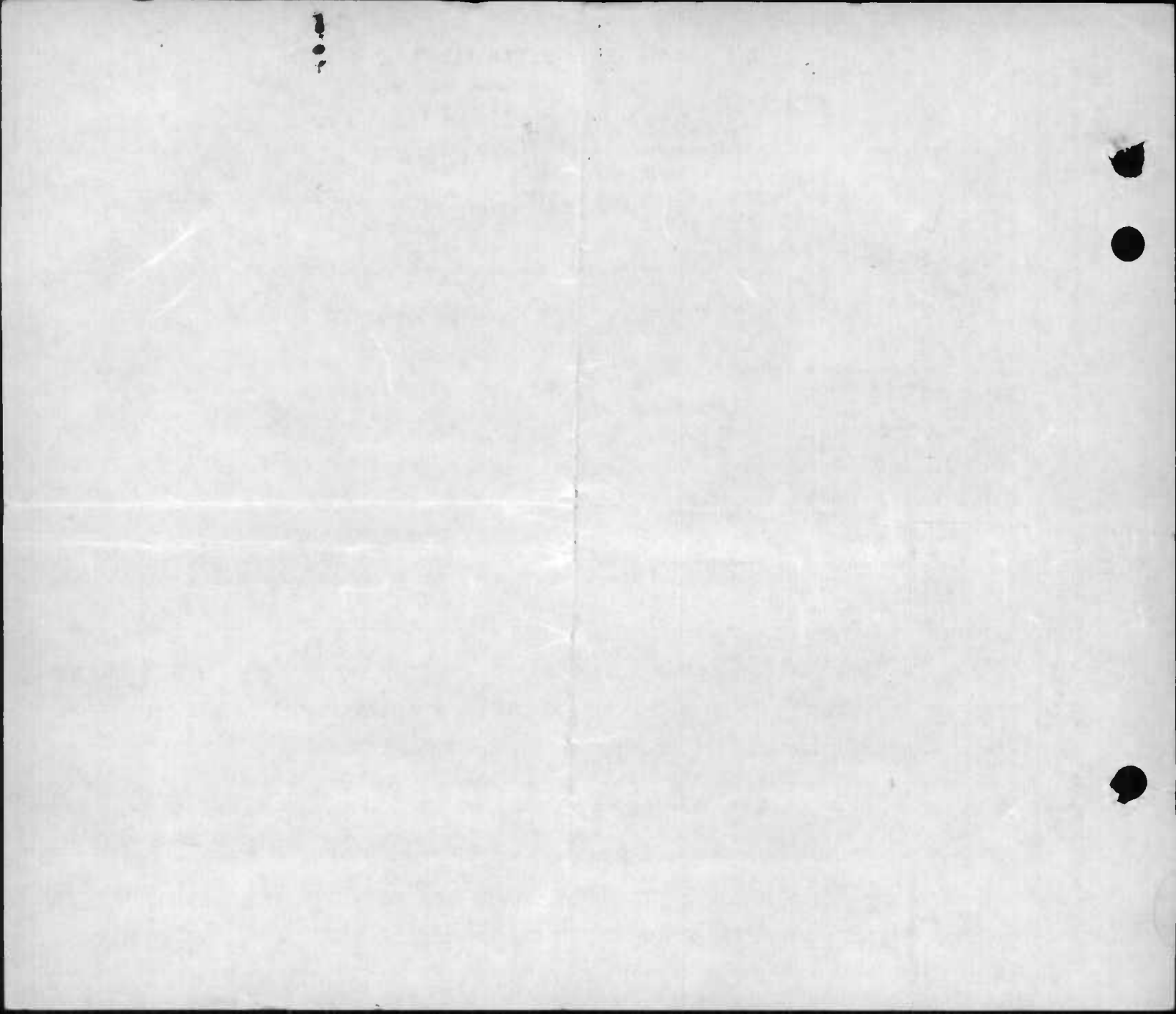
DATE SIGNED

23. BURIAL, CREMATION, REBURY (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (city, town, or county)	(State)
<u>Burial</u>	<u>4-25-56</u>	<u>Rosedale</u>	<u>Balto</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR		
		ADDRESS		
		<u>Jack Lewis Ave 2100 Cutters Pl</u>		

Phone call Dr. Palmer, Coroner. Bel Air as death sudden. I had not been called or consulted since Feb. 7, 1956.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Vollie</u> First <u>Minton</u> Last				4. DATE OF DEATH <u>April</u> Month <u>29</u> Day Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Pervis Minton</u>	
14. MOTHER'S MAIDEN NAME <u>Minerva Ellers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>241 40 8891</u>		17. INFORMANT <u>Mrs Vollie Minton</u> Address <u>Abingdon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Lerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Apr. 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reins-Sturdivant, Inc.</u>		22d. LOCATION (City, town, or county) <u>North Wilkesboro, Wilkes Co., N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u>				24. REC'D BY REGISTRAR <u>4/29/56</u>			
ADDRESS <u>Abingdon, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as being the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Medical History		Physical Examination		Mental Examination	
Laboratory Examinations		X-ray Examinations		Other Examinations	
Post-mortem Examination		Autopsy		Other	
Remarks		Remarks		Remarks	

BUREAU V. 3

MAY 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4096

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laneville Grace</u>		c. LENGTH OF STAY IN b. <u>3 days.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAGDOLENA</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>MAE</u> Last <u>CAKLEY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Mask Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Brady</u>		14. MOTHER'S MAIDEN NAME <u>MARY HORNBERGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-20-7169</u>	
17. INFORMANT <u>MADE E. COLLINS - SISTER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio</u> <u>420.1</u> DUE TO <u>Vascular Hypertension Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 25 1956</u> , to <u>April 26 1956</u> , that I last saw the deceased alive on <u>April 26 1956</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Harford Md 4/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 30, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs & Son</u> ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>May 1-1956</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		M		35		JAN 5 1921		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MOTHER'S MARRIAGE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		LABORER		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS DRUGS	
JAN 6 1968		MOBILE, ALABAMA		HEART DISEASE		NATURAL		2 WEEKS		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1968		JAN 10 1968		JAN 10 1968		JAN 10 1968		JAN 10 1968		JAN 10 1968		JAN 10 1968		JAN 10 1968	

BUREAU V. 2

JAN 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4097

CERTIFICATE OF DEATH

04106

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	
c. LENGTH OF STAY IN 1b 1 1/2 DAYS		d. STREET ADDRESS 721 REVOLUTION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle POLLITT Last POLLITT		4. DATE OF DEATH Month April Day 17 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 29, 1891
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM TRAVERS		14. MOTHER'S MAIDEN NAME MARY MARSHALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Sara West, 1231 Apple St. Wilm. Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema (c) Hypertensive Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14/56 , 19 56 , to 4/17/56 , 19 56 , that I last saw the deceased alive on 4/17/56 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. H. Wadsworth, M.D.		ADDRESS (Street, city or town, state) Harrel Grace, Md.	
PHYSICIAN'S NAME (Type) Wm. H. Wadsworth		DATE SIGNED 4/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/56	
22c. NAME OF CEMETERY OR CREMATORY Gravelawn Mem. Park		22d. LOCATION (City, town, or county) (State) Farmhurst, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Wadsworth		24a. REC'D BY REGISTRAR APR 17 1956 - G. L. Lewis M.D.	
ADDRESS Harrel Grace, Md.		24b. REGISTRAR'S SIGNATURE	

Item 9. Film G195 4-17-56 et.

4998

CERTIFICATE OF DEATH

04107

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		d. STREET ADDRESS <u>R.D. # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Orman</u> Last <u>Preston</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5th 1886</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer and Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alexander Preston</u>		14. MOTHER'S MAIDEN NAME <u>Alice Shay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. G. Orman Preston</u>		Address <u>Aberdeen #2 rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>56</u> , to <u>April 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>56</u> , and that death occurred at <u>7:53</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkitt, Jr.</u>		DATE SIGNED <u>4-5-56</u>	
PHYSICIAN'S NAME (Type) <u>Aberdeen, Maryland</u>		ADDRESS (Street, city or town, state) <u>617 W. Belair Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesleyan Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Rural Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarny Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 10-56</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. Jones</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>April 10, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Retired</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL <i>None</i>	
16. SIGNATURE OF DECEASED <i>John J. Jones</i>		17. SIGNATURE OF WITNESS <i>John J. Jones</i>		18. SIGNATURE OF PHYSICIAN <i>John J. Jones</i>	
19. SIGNATURE OF CORONER <i>John J. Jones</i>		20. SIGNATURE OF JURY <i>John J. Jones</i>		21. SIGNATURE OF JUDGE <i>John J. Jones</i>	
22. SIGNATURE OF CLERK <i>John J. Jones</i>		23. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		24. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
25. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		26. SIGNATURE OF CHIEF <i>John J. Jones</i>		27. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
28. SIGNATURE OF CLERK <i>John J. Jones</i>		29. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		30. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
31. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		32. SIGNATURE OF CHIEF <i>John J. Jones</i>		33. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
34. SIGNATURE OF CLERK <i>John J. Jones</i>		35. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		36. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
37. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		38. SIGNATURE OF CHIEF <i>John J. Jones</i>		39. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
40. SIGNATURE OF CLERK <i>John J. Jones</i>		41. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		42. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
43. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		44. SIGNATURE OF CHIEF <i>John J. Jones</i>		45. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
46. SIGNATURE OF CLERK <i>John J. Jones</i>		47. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		48. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
49. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		50. SIGNATURE OF CHIEF <i>John J. Jones</i>		51. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
52. SIGNATURE OF CLERK <i>John J. Jones</i>		53. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		54. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
55. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		56. SIGNATURE OF CHIEF <i>John J. Jones</i>		57. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
58. SIGNATURE OF CLERK <i>John J. Jones</i>		59. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		60. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
61. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		62. SIGNATURE OF CHIEF <i>John J. Jones</i>		63. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
64. SIGNATURE OF CLERK <i>John J. Jones</i>		65. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		66. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
67. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		68. SIGNATURE OF CHIEF <i>John J. Jones</i>		69. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
70. SIGNATURE OF CLERK <i>John J. Jones</i>		71. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		72. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
73. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		74. SIGNATURE OF CHIEF <i>John J. Jones</i>		75. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
76. SIGNATURE OF CLERK <i>John J. Jones</i>		77. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		78. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
79. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		80. SIGNATURE OF CHIEF <i>John J. Jones</i>		81. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
82. SIGNATURE OF CLERK <i>John J. Jones</i>		83. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		84. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
85. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		86. SIGNATURE OF CHIEF <i>John J. Jones</i>		87. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
88. SIGNATURE OF CLERK <i>John J. Jones</i>		89. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		90. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
91. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		92. SIGNATURE OF CHIEF <i>John J. Jones</i>		93. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
94. SIGNATURE OF CLERK <i>John J. Jones</i>		95. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		96. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	
97. SIGNATURE OF ASSISTANT <i>John J. Jones</i>		98. SIGNATURE OF CHIEF <i>John J. Jones</i>		99. SIGNATURE OF DEPUTY <i>John J. Jones</i>	
100. SIGNATURE OF CLERK <i>John J. Jones</i>		101. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		102. SIGNATURE OF ARCHIVIST <i>John J. Jones</i>	

RECEIVED
APR 11 1956
BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4099

CERTIFICATE OF DEATH

04108

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve-de-Bace</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forrest Hill</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Roberta Smith</u>			4. DATE OF DEATH Month Day Year <u>4 - 14 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11 - 1906</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Howard Martine</u>			14. MOTHER'S MAIDEN NAME <u>Hester May Pyles</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>No</u>		
17. INFORMANT <u>James Allen Smith</u> Address <u>Forrest Hill, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral hemorrhage</u> <u>445X</u> DUE TO (b) <u>Malignant hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u> <u>4 M.S.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>prolapsed uteri</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Nov.</u> , 1927, to <u>April 14, 1956</u> , that I last saw the deceased alive on <u>April 14</u> , 1956, and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.			ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>4/15/56</u>		
PHYSICIAN'S NAME (Type) <u>WILLARD P HUDSON</u>			<u>FOREST HILL, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Center Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. [unclear]</u> ADDRESS <u>[unclear] Md</u>			24a. REC'D BY REGISTRAR <u>DATE 4-16-56</u> 24b. REGISTRAR'S SIGNATURE <u>Prueella Lowwood</u>		

CERTIFICATE OF DEATH

1935

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>APR 10 1935</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>NEW YORK</i>	
10. OCCUPATION <i>CLERK</i>		11. MARITAL STATUS <i>MARRIED</i>		12. COLOR <i>WHITE</i>	
13. SIGNATURE OF PHYSICIAN <i>J. H. BROWN</i>		14. SIGNATURE OF REGISTRAR <i>W. H. GREEN</i>		15. SIGNATURE OF WITNESSES <i>...</i>	

BUREAU V. S.

APR 10 1935

RECEIVED

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON APRIL 10, 1935.

4121
CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryman</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Perryman</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Susan</i> Middle <i>Stansbury</i> Last				4. DATE OF DEATH Month <i>April</i> Day <i>8th</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7th 1872</i>	9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Webster</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Clark</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Olevia Stansbury Perryman, wid.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>Anteriosclerotic Heart disease</i> DUE TO (c) <i>Anteriosclerotic Heart disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/23</i> , 19 <i>53</i> , to <i>4/7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4/7</i> , 19 <i>56</i> , and that death occurred at <i>12:10 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>George T. Stansbury</i>				ADDRESS (Street, city or town, state) <i>568 Revolution St., Havre de Grace, Md.</i>			
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				DATE SIGNED <i>4/9/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 10-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union U.S. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen Rural. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Sarnig</i>				ADDRESS <i>Aberdeen Md.</i>			
24a. REC'D BY REGISTRAR <i>APR 11-56</i>				24b. REGISTRAR'S SIGNATURE <i>Mellie R Perry</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1121

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES E. BROWN		45		M		W		1880		BALTIMORE		MD.		U.S.A.			
MARRIED		YES		NO		YES		NO		YES		NO		YES		NO	
EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY		OTHER		EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY	
OCCUPATION		LABORER		CLERK		MERCHANT		PROFESSOR		OCCUPATION		LABORER		CLERK		MERCHANT	
CAUSE OF DEATH		HEART DISEASE		STROKE		CANCER		TUBERCULOSIS		CAUSE OF DEATH		HEART DISEASE		STROKE		CANCER	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE	
DATE OF DEATH		APR 12 1921		APR 12 1921		APR 12 1921		APR 12 1921		DATE OF DEATH		APR 12 1921		APR 12 1921		APR 12 1921	
PLACE OF DEATH		HOME		HOSPITAL		PRISON		OTHER		PLACE OF DEATH		HOME		HOSPITAL		PRISON	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MD.		MD.		MD.		MD.		STATE OF DEATH		MD.		MD.		MD.	
COUNTRY OF DEATH		U.S.A.		U.S.A.		U.S.A.		U.S.A.		COUNTRY OF DEATH		U.S.A.		U.S.A.		U.S.A.	
SIGNATURE OF DECEASED										SIGNATURE OF DECEASED							
SIGNATURE OF WITNESS										SIGNATURE OF WITNESS							
SIGNATURE OF PHYSICIAN										SIGNATURE OF PHYSICIAN							
SIGNATURE OF CLERK										SIGNATURE OF CLERK							

BUREAU V. S.

APR 12 1921

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4122

CERTIFICATE OF DEATH

04110

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUBLIN		c. LENGTH OF STAY IN 1b 74 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last SWIFT		4. DATE OF DEATH Month APRIL Day 25 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 12, 1881
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINEMAN		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO.	
11. BIRTHPLACE (State or foreign country) DUBLIN, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME MARILLA SWIFT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-09-3070	
17. INFORMANT MRS. MARY J. SWIFT, DARLINGTON, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cerebral and myocardial DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT , 19 55 , to APRIL , 19 56 , that I last saw the deceased alive on APRIL 23 , 19 56 , and that death occurred at 5:45 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dudley Phillips MD		ADDRESS (Street, city or town, state) Darlington Md. DATE SIGNED 4/25/56	
PHYSICIAN'S NAME (Type) Dudley Phillips MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-27-56	22c. NAME OF CEMETERY OR CREMATORY DUBLIN SOUTHERN	22d. LOCATION (City, town, or county) (State) DUBLIN, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.		24a. REC'D BY REGISTRAR DATE 4-30-56	24b. REGISTRAR'S SIGNATURE Marilla Howard

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1152

BUREAU V. 2

MAY 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04111

Reg. Dist. No.

18

4123

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 152</u>		d. STREET ADDRESS <u>Route 152</u>	
3. NAME OF DECEASED (Type or print) <u>Doris</u> First <u>Watson</u> Last		4. DATE OF DEATH <u>April</u> Month <u>25</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Wm. E. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Nichols</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>J. Oliver Watson</u>		Address <u>Route 152, Fallston, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 25, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louder Park</u>	22d. LOCATION (City, town, or county) <u>Balto. Md.</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HARRY H. WITZKE</u>		ADDRESS <u>4101 Baltimore Ave</u> CITY <u>BALTO.</u> STATE <u>MD.</u>	
24. READ BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		123 Main St, Boston		April 30, 1956		Home	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		POSTMORTEM		HISTOPATHOLOGY		LABORATORY		RADIOLOGY		OTHER		REMARKS		SIGNATURE OF EXAMINER		DATE	
Heart failure		Natural		None		None		None		None		None		None		None		[Signature]		April 30, 1956	

BUREAU V. 3

APR 30 1956

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